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Background and Purpose

The purpose of this "How To" Guide is to provide additional guidance on marketing issues that are discussed in the State Guide to Integrated Medicare & Medicaid Models[1]. It applies to the marketing of Special Needs Plans (SNP) in which a Medicare Advantage (MA) Organization contracts with both CMS and the state. As noted in the State Guide, CMS and the State review marketing materials for prospective enrollees of health plans, and also review informational and contract materials provided to beneficiaries enrolled in such plans. While an MA SNP may wish to develop separate marketing materials for Medicaid and Medicare beneficiaries—with duals receiving both sets of materials—the process can be streamlined, as discussed below. A streamlined approach can benefit Medicare and Medicaid, as well as being less burdensome for health plans and less confusing for beneficiaries.

Marketing Questions & Answers

1. *Does CMS allow the use of integrated Medicare and Medicaid marketing materials to market SNPs to dual eligibles (i.e., marketing material combining information on Medicare and Medicaid) and are there states that allow such integrated materials?*

   Yes, CMS does allow the use of integrated Medicare and Medicaid marketing materials and intends to develop "model" integrated marketing materials that can be used by SNPs that market to duals (including dual SNPs as well as other SNP plans that serve duals, such as those serving the institutionalized and individuals with chronic conditions). A number of states permit the use of integrated materials. For example, Massachusetts, Minnesota, and Wisconsin have used a single enrollment form for their combined Medicare Advantage / Medicaid products.

2. *Is there a streamlined process for gaining Medicare and Medicaid approval of combined SNP marketing materials?*

   In many cases, CMS regional offices and the States have worked together to create a streamlined process for review of marketing material on a "one-stop shopping" basis. The procedures are agreed to by CMS, the States, and health plans so that all parties understand the process and can work together to facilitate an efficient process. There are a number of approaches that can be used in defining a process for integrated review of marketing material.

   Below are two examples of possible review processes, one sequential and one simultaneous, reflecting approaches agreed upon in the past by CMS and State officials. These examples can be modified in detail to reflect decisions made between CMS and the State and to accommodate different State requirements. Note that the time frames

[1] http://www.cms.hhs.gov/DualEligible/04_StateGuidetoIntegratedMedicareandMedicaidModels.asp

referenced in the examples (45 days for "non-model" material; 5 days for "file and use") are standards for Medicare Advantage products.[2] States may have different time frames; therefore, one aspect of streamlining the process would be for CMS and the State to coordinate timelines. States should contact their CMS regional offices to begin discussions on developing a joint marketing material review process.

SCENARIO 1- Sequential Review

General Terms

- CMS and the State agree that all enrollee outreach and education materials, in all forms, shall require approval by CMS and the State prior to dissemination.
- Such materials shall include, but not be limited to:
  - Outreach, advertising, enrollment, and disenrollment materials;
  - Benefit coverage information (e.g., Member Handbook, Summary of Benefits);
  - Operational letters (e.g., for enrollment, claim denials, appeals); and
  - Provider-related materials (e.g., provider directory, primary care network list).
- Per 42 CFR 422.80 (Medicare Advantage regulations), there is up to a 45-day review period for all "non-model" materials. The State and CMS agree [in this example] to adhere to this timeframe for the combined review. This does not apply to "file and use" documents (which require five-day advance notice to CMS).
- A single point of entry should be negotiated between the State and CMS for the submission of and feedback on all marketing materials.*
- The State and CMS each maintain a tracking system that includes the standard marketing material submission requirements (e.g. log number, date, purpose of submission).
- The State and CMS reconcile their respective tracking systems on a quarterly basis, or more frequently if necessary.

Review Process

1. Plan submits materials electronically to the State [as single point of entry in this example]. The State logs the materials into its tracking system, starting the 45-day clock.
2. If any information is missing or incorrect, the State requests the information or works with the plan to make any corrections.
3. Once the State has approved the materials, but no later than 20 days after plan submission of complete materials, it forwards the materials to its CMS Regional Office for review.
4. CMS reviews the materials per the standard Medicare Advantage review (within the negotiated time frame) and is the final reviewer. CMS uses established date requirements, date stamps, etc. as part of the standard MA review process.
5. A joint letter detailing the reviewed submission and the outcome (approve, disapprove) is sent to the plan.
6. Any materials requiring edits (i.e., that were denied pending submission of edits) are resubmitted by the plan and follow steps 1-5 above until the submission is approved or withdrawn.

* Generally, states prefer to receive the marketing materials first and serve as the single point of entry. However, it is worth noting that New York has developed a process with its Regional Office (Region II) in which all marketing materials are submitted to the regional Medicare plan representatives first. All materials identified by the plans as being related to Medicaid on the CMS standard transmission form are immediately electronically passed through to the State for review. The State provides feedback to CMS regional representatives, and CMS (as single point for entry and feedback) communicates with the plans.

[2] For the definition of marketing materials in the MA program and review time frames, see chapters 5 and 9, respectively, in the Marketing Guidelines at:
http://www.cms.hhs.gov/ManagedCareMarketing/03_FinalPartCMarketingGuidelines.asp

SCENARIO 2 – Simultaneous Review (of 45-day material)

1. CMS (Medicaid and Medicare Managed care plan managers) meets with the State to develop a joint review process. [General terms of Scenario 1 would apply.]

2. CMS and the State meet with each of the health plans to review the process and to provide technical assistance. A detailed list of submission requirements (log#, date, purpose of submission, etc.) is explained during this meeting with each health plan. The submittal identification requirements are similar to those set forth in chapter 3 of the Marketing Guidelines.* [CMS and the State could review other MA requirements with the plans at this meeting, such as the dates by which plans must provide certain materials to enrollees, as set forth in CMS' annual Call Letter.]

3. The organization simultaneously submits marketing submissions to CMS and the State, triggering the 45-day review process. Each submission has a unique log# assigned to it.

4. CMS meets with the State on a bi-weekly basis to consolidate responses for each submission. Communications can take place by phone or via e-mail and can occur more frequently if needed.

5. Once CMS and the State review the submission and agree on the outcome then it is either approved or denied.
    a. Approved submissions are stamped approved.
    b. Denied submissions are stamped denied with the necessary changes/edits explained directly on the piece.
    c. CMS and the State consolidate their individual edits for each submission.
    d. A cover sheet detailing the reviewed submission, along with copies of each piece is forwarded (mail, fax, etc.) to the organization.
    e. CMS keeps the original submission.
    f. Both the state and CMS maintain a filing system and log to control and track marketing. It is helpful to reconcile the receipt log against the health plan submission list on a quarterly basis, or more frequently if indicated. [The CMS regional offices are in the process of transitioning to an automated tracking system (Health Plan Management System (HPMS) and CMS is examining how to include the state in this process.]

6. Any material requiring edits are resubmitted by the health plan to CMS/State and steps 3-5 are repeated until the marketing submission is approved.

* http://www.cms.hhs.gov/ManagedCareMarketing/03_FinalPartCMarketingGuidelines.asp

3. Is there a procedure whereby States can have a clear statement of Medicare Advantage requirements pertaining to marketing materials?

Medicare Advantage guidelines on marketing and member materials could be referenced in a Memorandum of Understanding (MOU) between Medicare and the State. The State of Minnesota has created such an agreement, which incorporates and consolidates both

Medicare Advantage and state policies. The specific language in their MOU is written below.

Marketing and Member Materials

Because these plans serve only a specified subset of the MA eligible population, the marketing rules will be interpreted to permit a Medicare Advantage Organization (MAO) to notify only the Minnesota Senior Health Options (MSHO) eligible population of non-disabled dual eligibles of MSHO open enrollment period, and direct any marketing materials towards this subset of the Medicare population.

The MAO will be permitted to notify only the Minnesota Disability Health Options (MnDHO) population of disabled individuals about the MnDHO open enrollment period, and direct any marketing materials towards this subset of the Medicare population.

CMS and the State agree that all outreach and education materials and activities shall continue to require approval by CMS and the State prior to dissemination. The MAO will submit materials to the State and the State then submits them to the CMS Regional Office for review. All materials will reflect both Medicare and Medicaid benefits.

Examples of materials covered by this process include: Certificate of Coverage (Evidence of Coverage), Member Handbook, Member ID card, marketing brochures, enrollment form, provider directory, primary care network list, new member welcome letter, etc.

All marketing and member materials and letters are integrated and reflect both Medicare and Medicaid services and policies so that there is one clear set of materials for all beneficiaries enrolled. The State and the CMS Regional Office will work together to determine specific language that best reflects both benefit sets.

4. *Can a SNP offer inducements to attract dual eligible enrollees to its plan?*

Although financial inducements to join a Medicare plan are prohibited, SNPs can attempt to encourage dual beneficiaries to enroll by offering services that are attractive to such beneficiaries or by including particular providers in the plan's network that duals might prefer. See Marketing Guidelines, chapter 6, for specific guidance on marketing activity for SNPs and outreach to dual eligible memberships. Also, chapter 11, *Guidelines for Promotional Activities*.

5. What can states do to inform members about integrated SNP plans and to encourage enrollment?

CMS encourages states to promote the benefits of enrollment into integrated managed care products for duals, while not directly marketing any one particular Medicare managed care plan. A State could include information in its managed care informing materials that:

- Explain which of their contracted plans offer an integrated Medicare-Medicaid product.
- Provide the local SHIP office with information on Medicare managed care options for Medicaid beneficiaries, including SNPs.
- Describe some of the potential benefits to receiving both Medicaid and Medicare services through an integrated care arrangement. State materials to eligibles could highlight:
  - Those SNP plans that have combined their Medicare and Medicaid material into a single set of integrated documents, explaining that members of these plans will have the advantage of having to refer to only one Explanation of Coverage (EOC) under Medicare and Medicaid.
  - That integrated SNPs may be able to handle authorizations, inquiries, and complaints about both a member's Medicare and Medicaid benefits in a single call - one source of authorizing care and solving problems.
  - That integrated SNPs may have staff dedicated to helping coordinate individual enrollees' Medicaid and Medicare services.

States can be creative and inclusive in their marketing activities, as indicated in the partnership example below:

> The State of Massachusetts has hired a marketing/promotions firm to promote enrolling in its MAPD Senior Care Options (SCO) demonstration plans. The governor's office authorized an aggressive outreach plan that includes a van tour to different communities, along with a video, handouts, by-line articles, and public service announcements. All of the promotional materials -- even what is painted on the side of the van -- were sent to CMS RO 1 for marketing review against the CMS marketing guidelines.
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> Additionally, Mass Health (Medicaid) sends out SCO postcards and birthday cards to notify the potential enrollees of the MAPD program. When recipients call back to the state, they are given the names and phone numbers of all the plans in their service area so that they may get additional information and/or learn how to enroll.
>
> Enrollments are increasing; the plans generally like the outreach (marketing) that the State is doing; and CMS is pleased to have been included in the process.

6. *Is it possible to require a beneficiary to be enrolled in a SNP plan for Medicare coverage?*

   Medicaid can require a Medicare beneficiary to enroll in a Medicaid managed care plan for Medicaid services, but a Medicare beneficiary cannot be required to be a member of a Medicare managed care plan. However, CMS will consider proposals from States or Medicare Advantage Plans to permit seamless transition of individuals who are in a Medicaid managed care plan into a Medicare SNP offered by the same managed care organization when they first become eligible for Medicare.

   Keep in mind that unlike most Medicare beneficiaries, dual eligible beneficiaries would have an ongoing Special Election Period (SEP) which permits enrollment in and disenrollment from Medicare Advantage plans on a month-by-month basis.

   Because dual eligibles may periodically lose their Medicaid eligibility, organizations contracting with CMS and the state may want to administer a Medicare-only benefit, as well as the duals SNP product.